OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

July 22, 2025

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Welcome, Call to Order, and Roll Call

HCAI

Department of Health Care Access and Information

Agenda

Item #1 **Welcome, Call to Order, and Roll Call**
Secretary Kim Johnson, Chair

Item #2 **Executive Updates**
Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director

Item #3 **Action Consent Item**
Vote to Approve June 9, 2025 Meeting Minutes
Vishaal Pegany

Item #4 **Action Item**
Vote to Appoint Advisory Committee Members (Out-of-Order)
Megan Brubaker, Engagement and Governance Group Manager

Item #5 **Informational Items**

a) Update on Behavioral Health Spending Definition and Measurement Methodology (Out-of-Order)
Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager

b) Timeline of Changes under Federal Budget Reconciliation (H.R. 1)
Vishaal Pegany

c) Discussion of Data Submission Enforcement
Vishaal Pegany; CJ Howard, Assistant Deputy Director

d) Introduction to Spending Target Enforcement and Timeline
Vishaal Pegany; CJ Howard

Item #6 **General Public Comment**

Item #7 **Adjournment**

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

HCAI
Department of Health Care Access and Information

National Health Expenditures (NHE) 2024 Projections

- National health care spending is projected to reach $5.3 trillion in 2024, with per capita expenditures averaging $15,610 — a 7.1% increase over 2023, slightly above the prior year's growth (7.0%) and the 2020–2022 average (6.0%).
- Medicaid per enrollee spending is expected to rise 15.2% in 2024, reaching $10,951, more than doubling 2023's growth rate (7.1%) and far exceeding the 1.7% average from 2020–2022. This acceleration reflects the impact of eligibility redeterminations that disproportionately removed younger, lower-cost individuals, increasing average spending.
- Private health insurance (PHI) spending is projected to grow 7.7%, reaching $7,608 per person. This reflects strong utilization and Marketplace enrollment gains. Growth remains well above the 2020–2022 average of 4.1%, despite slowing from 9.7% in 2023.
- Medicare spending is projected to grow 6.7% in 2024, reaching $16,860 per person—up from 5.9% in 2023 and above the 3.8% average growth observed from 2020 to 2022. This increase reflects steady enrollment growth and higher prescription drug spending.

Source: Keehan, S. P., Madison, A. J., Poisal, J. A., Cuckler, G. A., Smith, S. D., Sisko, A. M., Fiore, J. A., & Rennie, K. E. (2025). *National health expenditure projections, 2024–33: Despite insurance coverage declines, health to grow as share of GDP*. *Health Affairs, 44*(7). https://doi.org/10.1377/hlthaff.2025.00545

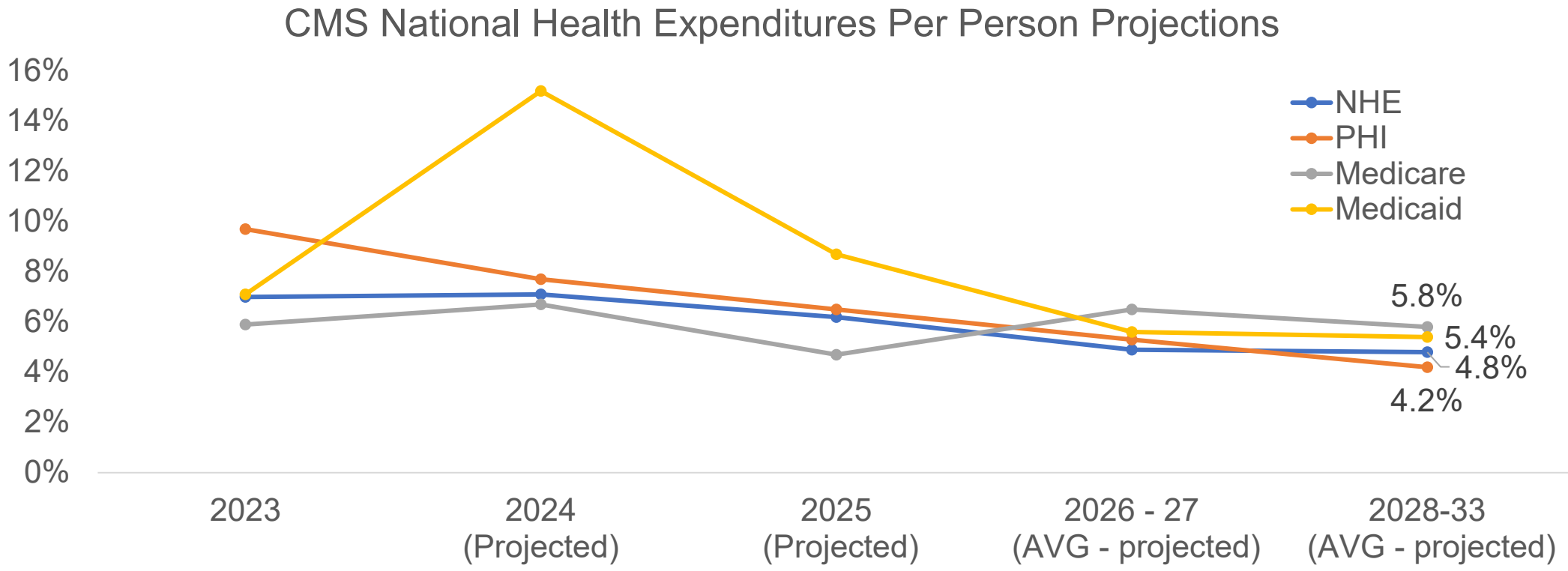
National Health Expenditures (NHE) 2024 Growth Drivers

- The insured rate dipped from 92.5% in 2023 to 92.1% in 2024, reflecting Medicaid redeterminations partially offset by Marketplace and employer gains.
- Spending growth in 2024 is primarily attributed to continued post-pandemic increases in utilization of services and goods, especially among privately insured populations.
- Health care prices rose 3.0% in 2024, matching 2023, but above the 2.5% average growth from 2020–2022.
- Three Largest Spending Categories:
  - Hospital care (32% of NHE) is projected to grow 9.2% in 2024—slightly below 2023's 10.4%, but significantly higher than the 2.9% 2020 to 2022 average. 2023 and 2024 mark the fastest hospital spending growth since 1990 (10.8%).
  - Physician and clinical services (20% of NHE) are expected to grow 7.8%, slightly above both 2023's 7.4% and the recent average of 6.0%.
  - Prescription drug spending (9% of NHE) is projected to rise 10.1%, down from 11.4% in 2023 but still well above the 6.2% average from 2020–2022.

Source: Keehan, S. P., Madison, A. J., Poisal, J. A., Cuckler, G. A., Smith, S. D., Sisko, A. M., Fiore, J. A., & Rennie, K. E. (2025). *National health expenditure projections, 2024–33: Despite insurance coverage declines, health to grow as share of GDP*. *Health Affairs, 44*(7). https://doi.org/10.1377/hlthaff.2025.00545

National Health Expenditures (NHE) Projections

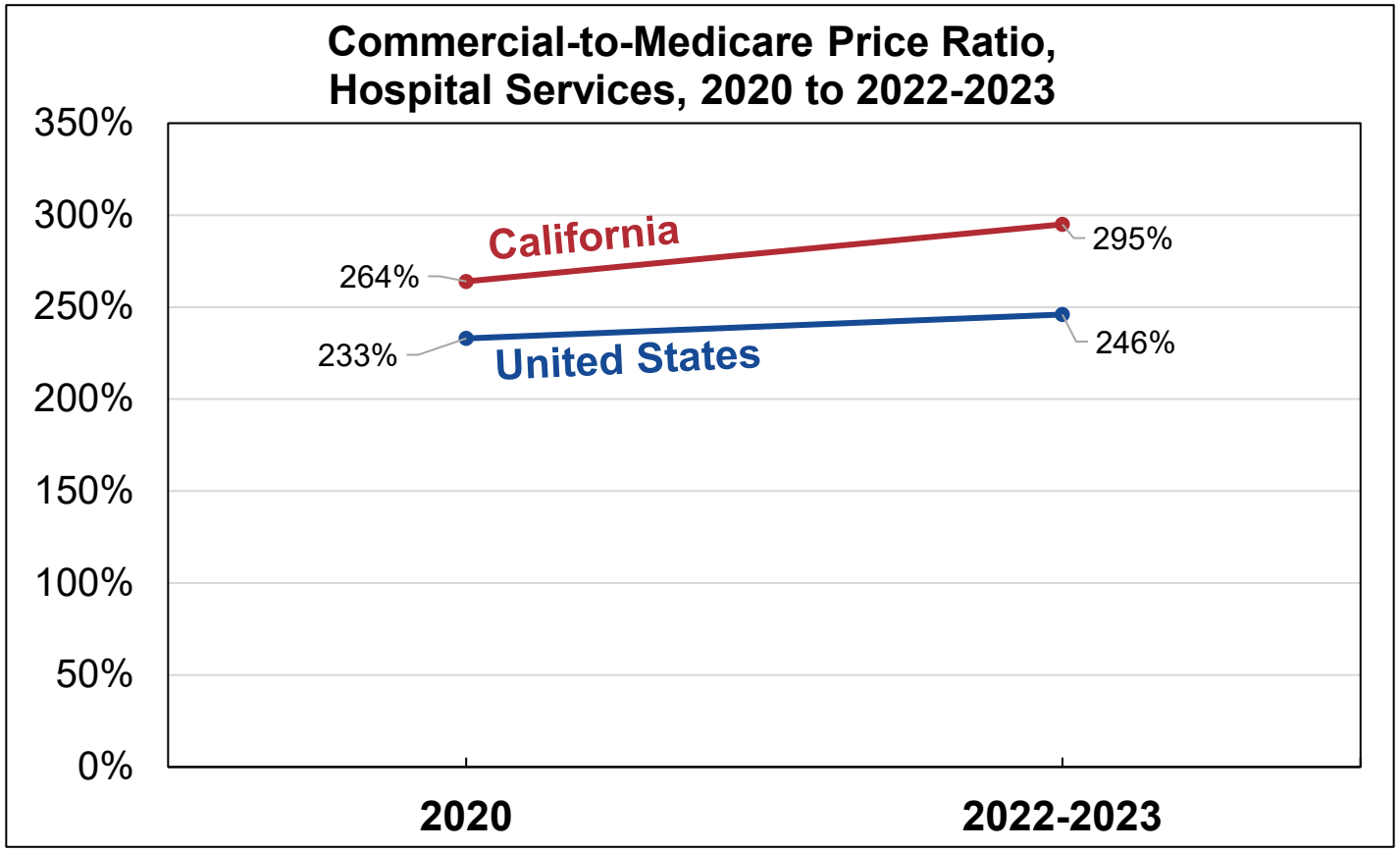
CMS projects a transitional slowdown in 2026–27 (5.6% growth), then steady growth of 4.8% annually through 2033. PHI is expected to grow the slowest at 4.2%, while Medicare and Medicaid continue to grow more quickly—at 5.8% and 5.4% driven by rising prices and increased utilization.



Source: Keehan, S. P., Madison, A. J., Poisal, J. A., Cuckler, G. A., Smith, S. D., Sisko, A. M., Fiore, J. A., & Rennie, K. E. (2025). *National health expenditure projections, 2024–33: Despite insurance coverage declines, health to grow as share of GDP*. *Health Affairs, 44*(7). https://doi.org/10.1377/hlthaff.2025.00545

Commercial to Medicare Price Gap Widens

- From 2020 to 2022-2023, the Commercial-to-Medicare Price Ratio for hospital services rose by **5.5% nationally** and **11.7% in California**.



Market factors associated with prices:

- Higher prices were more likely with
  - **very high hospital concentration levels**,
  - **a major teaching hospital**,
  - **higher share of the uninsured**,
  - **higher average income**
- Lower prices were more likely with
  - **high insurer concentration levels**

Source: Blavin F, Holahan J. Potential Factors Associated With Commercial-to-Medicare Relative Prices at the Substate Level. JAMA Health Forum. 2025;6(7):e251640. doi:10.1001/jamahealthforum.2025.1640

Cost and Market Impact Review: Covenant Care

- Covenant Care California LLC (“Covenant Care”) submitted a Material Change Transaction regarding the transfer of skilled nursing facilities and assisted living facilities (assets, operations, and leases), which was deemed complete on April 24, 2025.

- OHCA is proceeding to a Cost and Market Impact Review for three Covenant Care facilities that will be operated by entities affiliated with The Ensign Group, Inc. after the transaction closes:
  - Buena Vista Care Center in Santa Barbara County
  - Shoreline Care Center in Ventura County
  - Huntington Park Nursing Center in Los Angeles County

- OHCA will publish the Preliminary CMIR Report on its website and allow 10 business days for parties and the public to submit written comments in response to the findings.

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAI

Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Action Consent Item: Vote to Approve June 9, 2025 Meeting Minutes

HCAI
Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Public Comment

HCAI
Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Informational Items

HCAI
Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Update on Behavioral Health Spending Definition and Measurement Methodology

Margareta Brandt, Assistant Deputy Director
Debbie Lindes, Health Care Delivery System Group Manager

HCAI
Department of Health Care Access and Information

Primary Care & Behavioral Health Investments

Statutory Requirements

- Measure and promote a sustained systemwide investment in primary care and behavioral health.
- **Measure the percentage of total health care expenditures allocated to primary care and behavioral health** and set spending benchmarks that consider current and historic underfunding of primary care services.
- **Develop benchmarks** with the intent to build and sustain infrastructure and capacity and shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in primary care and behavioral health.
- Promote improved outcomes for primary care and behavioral health.

Update on Behavioral Health Investment Benchmark

- Deferred setting benchmark this year.
- Will revisit in summer 2026, with additional data and experience to inform deliberations.
- Behavioral health spending data submitted to OHCA in September 2026 will be used only for measurement and reporting, not comparison to a benchmark, for at least one year.

Behavioral Health Spending Measurement

1. **Schedule**
   - Payers will submit aggregate behavioral health spending data beginning in September 2026, covering the years 2024-2025.
   - OHCA will release the first report on behavioral health spending, using this data, in the summer of 2027.
2. **Data Submitters**
   - Payers and fully integrated delivery systems:
     - Commercial plans
     - Medicare Advantage plans
     - Medi-Cal managed care plans

Behavioral Health Spending Measurement

3. What Will Be Submitted

- Claims and non-claims payments for behavioral health care (as defined by OHCA).
- Aggregated by performance year and market category.
- Using the Expanded Non-Claims Payments Framework categories and subcategories for analysis and reporting.
- Behavioral Health in Primary Care Module with an expanded primary care provider list to capture integrated behavioral health spend.

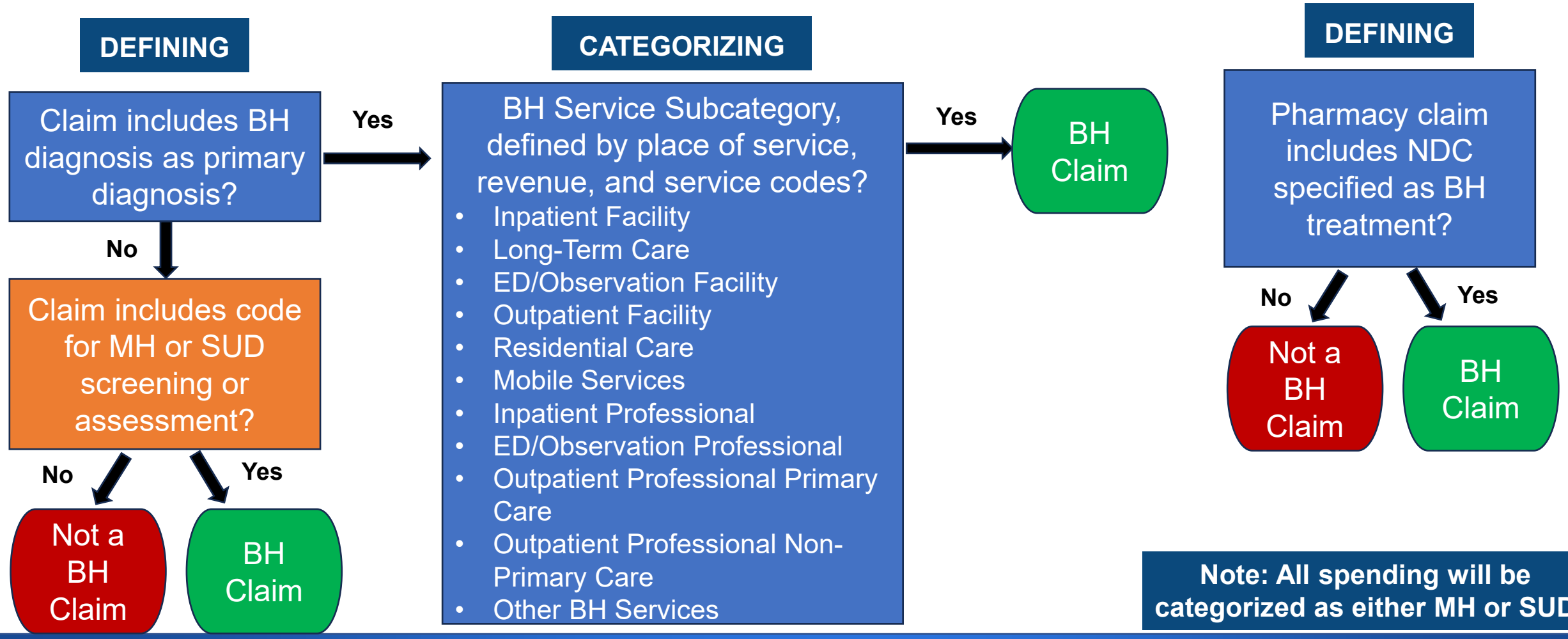
Detailed methodology will be included in the Data Submission Guide to be finalized spring 2026.

Measuring Behavioral Health Claims-Based Spending

Behavioral Health Claims Measurement Definition Principles

1. **Include all claims with a primary behavioral health diagnosis** in measurement.
   - Claims with service codes for mental health or substance use disorder screening or assessment also included, regardless of primary diagnosis code.
2. **Categorize claims** using place of service, revenue, and service codes.
   - "Other Behavioral Health Services" category captures claims with a primary behavioral health diagnosis code that do not have a place of service, revenue, or service code associated with another subcategory.
3. **Include pharmacy claims** with a National Drug Code (NDC) specified by OHCA as a behavioral health treatment.
   - Measured separately, so can be included or excluded for analysis.
   - Categorized as mental health or substance use disorder claims.
   - Behavioral health diagnosis not required.

Process Map for Identifying Behavioral Health (BH) Claims



Note: All spending will be categorized as either MH or SUD

Previously Proposed Behavioral Health Reporting Subcategories

Reporting Categories	Service Subcategories
Outpatient/Community Based	Community Based Mobile Clinic Services
	Outpatient Professional Primary Care
	Outpatient Professional Non-Primary Care
	Outpatient Facility
Emergency Department	Emergency Department / Observation; Facility
	Emergency Department / Observation; Professional
Inpatient	Inpatient; Facility
	Inpatient; Professional
Long-Term Care and Residential	Long-term Care
	Residential Care
Other†	Other Behavioral Health Services
Pharmacy	Mental Health (MH) Prescription Drug Treatments Substance Use Disorder (SUD) Prescription Drug Treatments

†All spending for claims with a primary behavioral health diagnosis is included (i.e., spending not in other subcategories goes to "Other").

Rationale for Proposed Revisions to Behavioral Health Reporting Subcategories

- Changes to subcategories do not impact total spending.* Only impacts aggregate categorization of spending.
- Folding Community-Based Mobile Clinic Services and Crisis Care into Outpatient subcategories minimizes data submitter burden.
- OHCA can leverage the Health Care Payments Database to measure and monitor changes in mobile clinic services and crisis care spend.
- Based on preliminary HPD results there was little to no commercial and Medicare spending on mobile clinic services spend from 2018 to 2023. There was about 4% of behavioral health spend from this category for Medi-Cal data in the HPD.
- HPD data also showed little or no spending in the long-term care subcategory in the 2018-2023 period. With this limited spending, OHCA proposes folding long-term care services into Other Services.

*Spending not categorized is included in “Other Services.”

Behavioral Health Spending in the Commercial Market by Service Subcategory, 2018-2023

Service Subcategory	2018	2019	2020	2021	2022	2023
Outpatient Professional Non-Primary Care	33.0%	36.9%	39.3%	37.9%	38.3%	42.7%
Pharmacy	22.5%	20.7%	18.1%	20.9%	20.4%	18.4%
Inpatient Facility	16.4%	15.3%	14.6%	13.0%	11.9%	10.4%
Other	8.2%	6.1%	6.1%	6.6%	7.2%	7.3%
Outpatient Facility Non-Primary Care	7.4%	7.1%	7.3%	7.5%	7.2%	6.9%
Emergency Dept/Observation	5.3%	5.2%	4.5%	4.2%	3.9%	3.4%
Residential Facility	4.4%	5.8%	7.5%	7.5%	8.4%	8.7%
Outpatient Professional Primary Care	1.7%	1.8%	1.7%	1.7%	2.0%	1.6%
Inpatient Professional	1.0%	0.9%	0.9%	0.7%	0.7%	0.6%
Mobile Services	0.1%	0.1%	0.1%	<0.1%	<0.1%	<0.1%
Long-Term Care	<0.1%	<0.1%	<0.1%	<0.1%	<0.1%	*

Preliminary analysis of HPD data.
*Data not included to comply with de-identification requirements.

Mental Health Spending in the Commercial Market by Service Subcategory, 2018-2023

Service Subcategory	2018	2019	2020	2021	2022	2023
Outpatient Professional Non-Primary Care	36.5%	40.7%	44.0%	42.4%	43.0%	48.0%
Pharmacy	24.6%	22.7%	20.0%	23.0%	22.5%	20.2%
Inpatient Facility	14.2%	13.6%	12.8%	11.4%	10.3%	8.7%
Other Services	8.4%	6.1%	6.1%	6.2%	7.0%	7.3%
Outpatient Facility Non-Primary Care	6.5%	6.5%	6.6%	6.9%	6.6%	6.1%
Emergency Dep/Observation	4.1%	4.0%	3.5%	3.3%	3.0%	2.6%
Residential Facility	2.7%	3.5%	4.3%	4.2%	4.7%	4.7%
Outpatient Professional Primary Care	1.8%	2.0%	1.8%	1.9%	2.2%	1.8%
Inpatient Professional	1.0%	0.9%	0.9%	0.8%	0.7%	0.6%
Mobile Services	0.1%	0.1%	0.1%	<0.1%	<0.1%	<0.1%
Long-Term Care	*	<0.1%	*	<0.1%	*	*

Preliminary analysis of HPD data.
*Data not included to comply with de-identification requirements.

Substance Use Disorder Spending in the Commercial Market by Service Subcategory, 2018-2023

Service Subcategory	2018	2019	2020	2021	2022	2023
Inpatient Facility	33.0%	29.3%	27.9%	24.8%	23.2%	22.4%
Residential Facility	17.2%	24.7%	30.7%	31.6%	35.5%	37.6%
Emergency Dept/Obs	15.3%	15.5%	11.6%	11.1%	10.5%	9.3%
Outpatient Facility Non-Primary Care	15.1%	11.9%	12.3%	11.8%	11.0%	12.4%
Other	6.4%	6.3%	6.2%	9.3%	8.9%	7.7%
Pharmacy	6.0%	5.0%	4.4%	5.2%	5.3%	5.3%
Outpatient Professional Non-Primary Care	5.2%	5.6%	5.3%	4.6%	4.3%	4.3%
Outpatient Professional Primary Care	0.9%	0.8%	0.7%	0.7%	0.7%	0.5%
Inpatient Professional	0.9%	0.9%	0.8%	0.7%	0.6%	0.5%
Long-Term Care	<0.1%	<0.1%	<0.1%	<0.1%	<0.1%	*
Mobile Services	*	*	*	*	*	*

Preliminary analysis of HPD data.
*Data not included to comply with de-identification requirements.

Revised Behavioral Health Reporting Subcategories

Reporting Categories	Service Subcategories
Outpatient/Community Based	Outpatient Professional Primary Care
	Outpatient Professional Non-Primary Care
	Outpatient Facility
Emergency Department	Emergency Department / Observation; Facility
	Emergency Department / Observation; Professional
Inpatient	Inpatient; Facility
	Inpatient; Professional
Residential	Residential Care
Other†	Other Behavioral Health Services
Pharmacy	Mental Health (MH) Prescription Drug Treatments Substance Use Disorder (SUD) Prescription Drug Treatments

†All spending for claims with a primary behavioral health diagnosis is included (i.e., spending not in other subcategories goes to "Other").

Measuring Behavioral Health Non-Claims Spending

Behavioral Health Non-Claims Measurement Definition Principles

- Data collection via Expanded Non-Claims Payments Framework.
- Include all behavioral health non-claims subcategories.
- Allocate payments to behavioral health by various methods:
  - **Population health, behavioral health integration, and care management payments** only when paid to behavioral health providers.
  - **Practice transformation, IT infrastructure, and other analytics payments** not to exceed a set upper limit.
  - **Behavioral health capitation payments** included in full.
  - **Professional and global capitation payments** and **payments to integrated, comprehensive payment and delivery systems** allocated to behavioral health using a method similar to that for primary care.

Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Spending
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	Include payments to behavioral health providers and provider organizations for care management/coordination and for integration with primary care or social care.
A2	Primary care and behavioral health integration*	
A3	Social care integration	
A4	Practice transformation payments	Limit the portion of practice transformation and IT infrastructure payments allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health.
A5	EHR/HIT infrastructure and other data analytics payments	
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	Include performance incentives in recognition of reporting, quality, and outcomes made to behavioral health providers.
B2	Retrospective/prospective incentive payments: pay-for-performance	

*May be paid to primary care or multi-specialty provider organizations for this purpose.

Overview of Recommended Non-claims Behavioral Health Care Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	Not Applicable
C2	Procedure-related, episode-based payments with risk of recoupments	
C3	Condition-related, episode-based payments with shared savings	Include spending for service bundles for a behavioral health-related episode of care.
C4	Condition-related, episode-based payments with risk of recoupments	
C5	Risk for total cost of care (e.g., ACO) with shared savings	Not Applicable
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	

Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	Not Applicable
D2	Professional capitation	Calculate a fee-for-service equivalent based on a fee schedule for behavioral health services multiplied by the number of encounters.
D3	Facility capitation	Not Applicable
D4	Behavioral Health capitation	Allocate full behavioral health care capitation amount to behavioral health care spending.
D5	Global capitation	Calculate a fee-for-service equivalent based on a fee schedule for behavioral health services multiplied by the number of encounters.
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	
E	Other Non-Claims Payments	Limit the portion of other non-claims payments* allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health.
F	Pharmacy Rebates	Not Applicable

*May include retroactive denials, overpayments, payments made as the result of an audit, or other payments that cannot be categorized elsewhere.

Equation for Allocating Practice Transformation, EHR/HIT, and Other Non-Claims Payments to Behavioral Health

$$\text{Subcategory A4 Behavioral Health Spend*} = \Sigma \text{ Practice Transformation Payments} \times \frac{\text{Behavioral Health Claims + Behavioral Health Portion of Capitation Payments}}{\text{Claims: Total Claims + Capitation and Full Risk Payments}}$$

*This equation would also be used to allocate Category A5 EHR/HIT Infrastructure and Data Analytics and Category E Other Non-Claims Payments to behavioral health.

Apportioning Professional and Global Capitation to Behavioral Health

Example for a Professional Capitation arrangement:

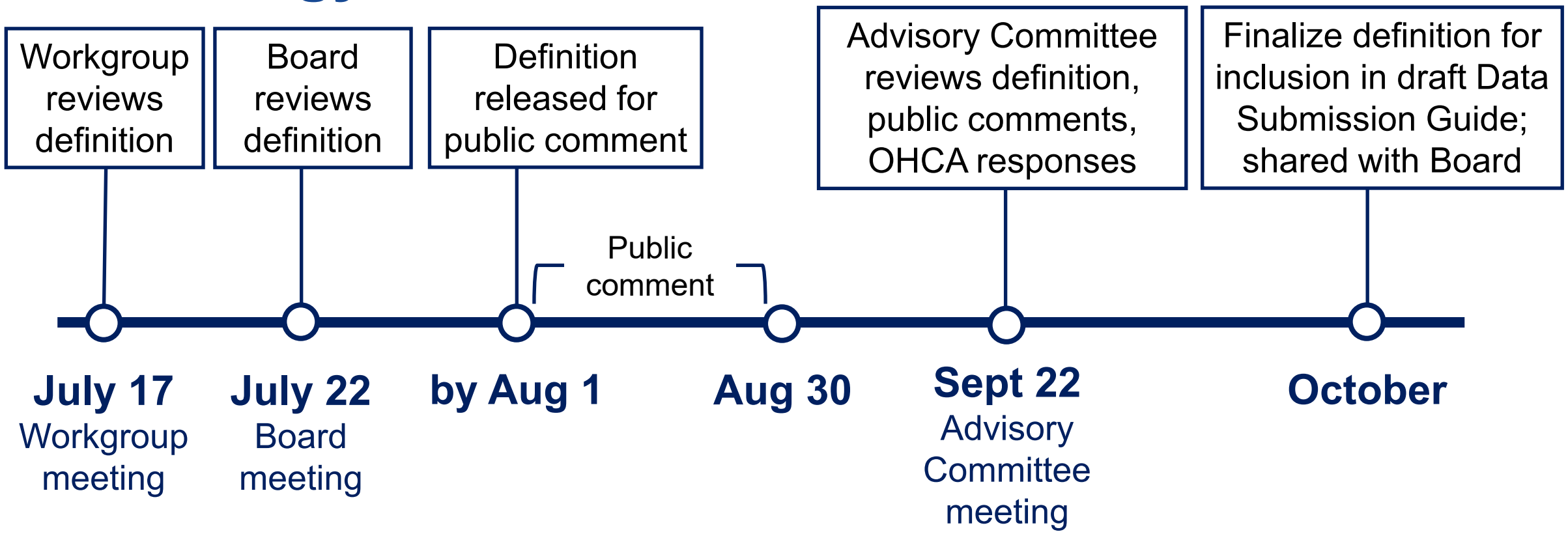
$$\frac{\Sigma\ (\#\ \text{of BH Encounters x FFS-equivalent Fee})_{segment}}{\Sigma\ (\#\ \text{of All Professional Encounters x FFS-equivalent Fee})_{segment}} = \text{Behavioral Health spend paid via professional capitation}$$

x Professional Capitation Payment

"Segment" means the combination of payer type (e.g., Medicaid, commercial), payer, year and region or other geography as appropriate.

Note: Methodology aligns with OHCA primary care approach.

Timeline for Finalizing Definition and Measurement Methodology



OHCA will work with DHCS and Medi-Cal managed care plans over the summer and fall to ensure the definition reflects managed care plan spending.

Behavioral Health Spending Definition and Measurement Methodology

Does the Board have any additional feedback on the definition and measurement methodology?

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAI

Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Action Item: Vote to Appoint Advisory Committee Members

HCAI
Department of Health Care Access and Information

Advisory Committee Member Selection April – July 2025

April 15
Close AC solicitation

May
Evaluate submissions

May
Physician Recruitment

June – July
Subcommittee Meetings

July 22 Board Meeting
Present potential slate to Board

Appoint AC members

Applicant Pool

First posting (in April):

- 42 total submissions
  - 8 incumbents
  - 34 new applicants

After outreach (in May):

- 25 Physician submissions

Advisory Committee Members – 28

Payers

Aliza Arjoyan
Senior Vice President of Provider Partnership and Network Management, Blue Shield of California

Yolanda Richardson
Chief Executive Officer, San Francisco Health Plan

Andrew See
Senior Vice President, Chief Actuary, Kaiser Foundation Health Plan

Hospitals

Barry Arbuckle
President & Chief Executive Officer, MemorialCare Health System

Tam Ma
Associate Vice President, Health Policy and Regulatory Affairs, University of California Health

Travis Lakey
Chief Financial Officer, Mayers Memorial Hospital District

Medical Groups

Hector Flores
Medical Director, Family Care Specialists Medical Group

Stacey Hrountas
Chief Executive Officer, Sharp Rees-Stealy Medical Centers

David S. Joyner
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Adam Dougherty
Emergency Physician, Vituity

Parker Duncan Diaz
Clinician Lead, Santa Rosa Community Health

Sumana Reddy
President, Acacia Family Medical Group

Purchasers

Ken Stuart
Chairman, California Health Care Coalition

Suzanne Usaj
Senior Director, Total Rewards, The Wonderful Company LLC

vacant

Health Care Workers

Stephanie Cline
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez
Physician Assistant, Altura Centers for Health

Consumer Representatives & Advocates

Carolyn J Nava
Senior Systems Change, Disability Action Center

Mike Odeh
Senior Director of Health, Children Now

Kiran Savage-Sangwan
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Rene Williams
Vice President of Operations, United American Indian Involvement

Marielle A. Reataza
Executive Director, National Asian Pacific American Families Against Substance Abuse (NAPAFASA)

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

Carmen Comsti
Lead Regulatory Policy Specialist, California Nurses Association/National Nurses United

Janice O'Malley
Legislative Advocate, American Federation of State, County and Municipal Employees

Kati Bassler
President, California Federation of Teachers, Salinas Valley

Academics/ Researchers

Stephen Shortell
Professor, UC Berkeley School of Public Health

12 outgoing positions highlighted

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Recommended Slate – 28

Payers

Aliza Arjoyan
Senior Vice President of Provider Partnership and Network Management, Blue Shield of California

Manan Shah ★
Elevance Health / Anthem Blue Cross of California

Andrew See ★
Senior Vice President, Chief Actuary, Kaiser Foundation Health Plan

Hospitals

Barry Arbuckle
President & Chief Executive Officer, MemorialCare Health System

Tam Ma ★
Associate Vice President, Health Policy and Regulatory Affairs, University of California Health

Travis Lakey ★
Chief Financial Officer, Mayers Memorial Hospital District

Medical Groups

Hector Flores
Medical Director, Family Care Specialists Medical Group

Stacey Hrountas
Chief Executive Officer, Sharp Rees-Stealy Medical Centers

David S. Joyner ★
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Adam Dougherty
Emergency Physician, Vituity

Michael Weiss ★
Children's Hospital of Orange County

Sumana Reddy ★
President, Acacia Family Medical Group

Purchasers

Ken Stuart
Chairman, California Health Care Coalition

Suzanne Usaj
Senior Director, Total Rewards, The Wonderful Company LLC

Iftikhar Hussain ★
San Francisco Health Service System

Health Care Workers

Stephanie Cline
Respiratory Therapist, Kaiser

Sarah Soroken ★
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez
Physician Assistant, Altura Centers for Health

Consumer Representatives & Advocates

Carolyn J Nava
Senior Systems Change, Disability Action Center

Mike Odeh
Senior Director of Health, Children Now

Kiran Savage-Sangwan ★
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Amanda McAllister-Wallner ★
Health Access

Marielle A. Reataza
Executive Director, National Asian Pacific American Families Against Substance Abuse (NAPAFASA)

Organized Labor

Joan Allen ★
Government Relations Advocate, SEIU United Healthcare Workers West

Carmen Comsti
Lead Regulatory Policy Specialist, California Nurses Association/National Nurses United

Janice O'Malley
Legislative Advocate, American Federation of State, County and Municipal Employees

Kati Bassler
President, California Federation of Teachers, Salinas Valley

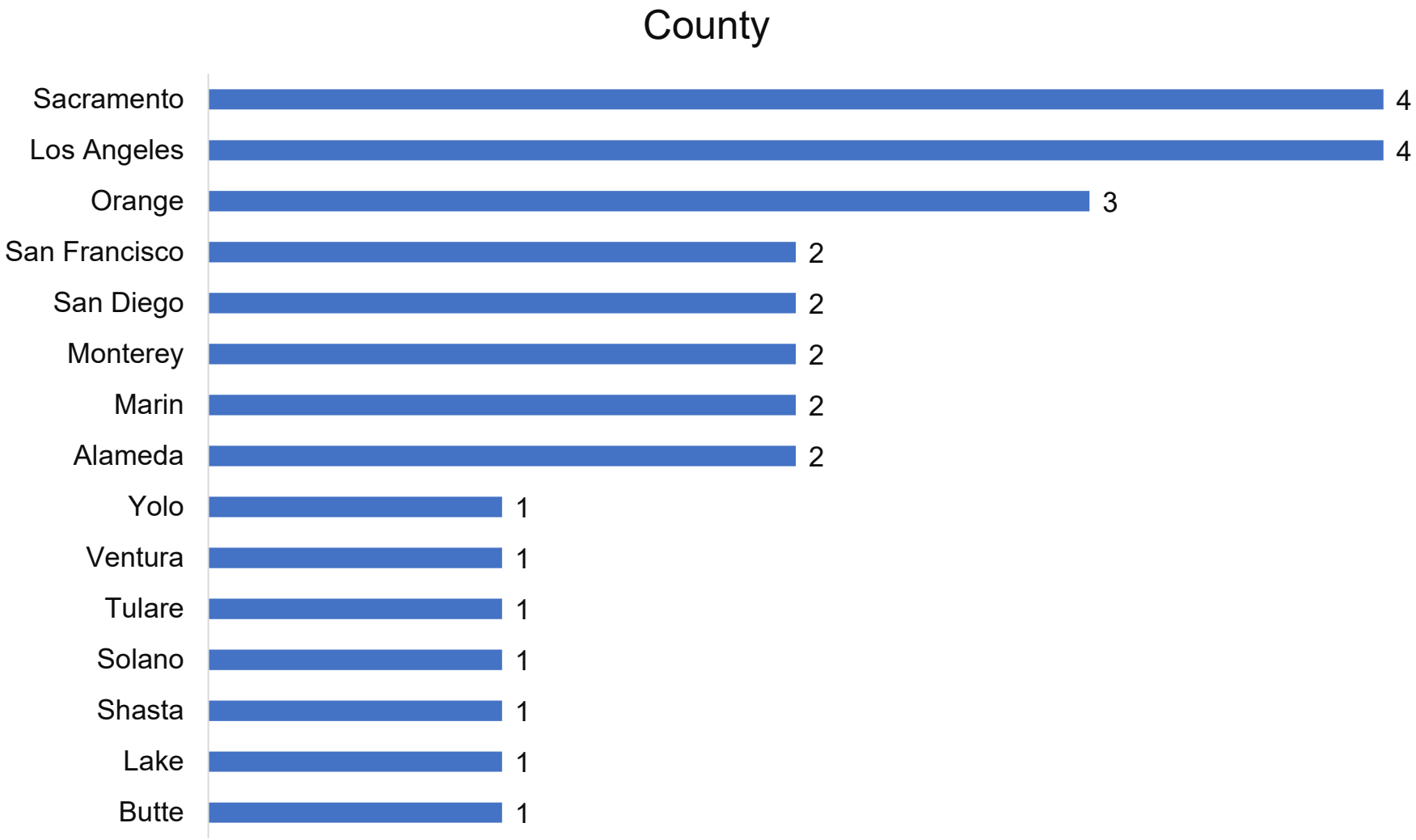
Academics/ Researchers

Stephen Shortell
Professor, UC Berkeley School of Public Health

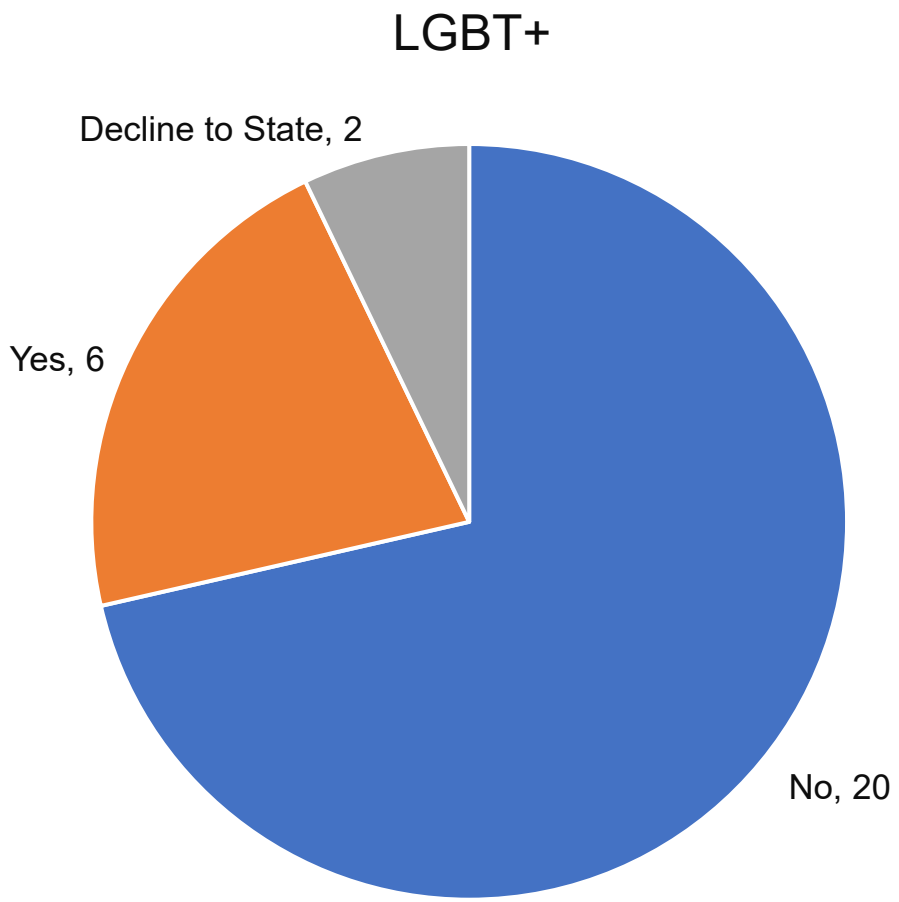
★ New or reappointment

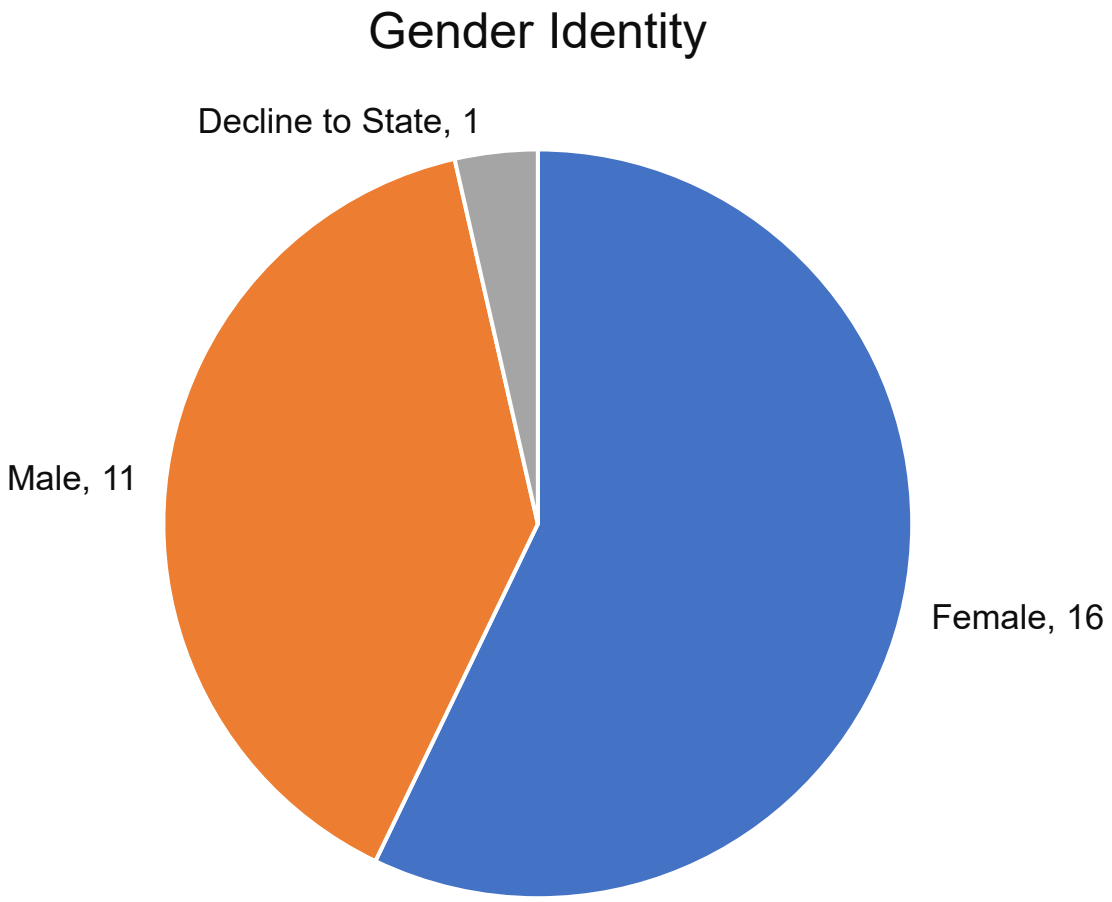
OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Demographics of Recommended Slate

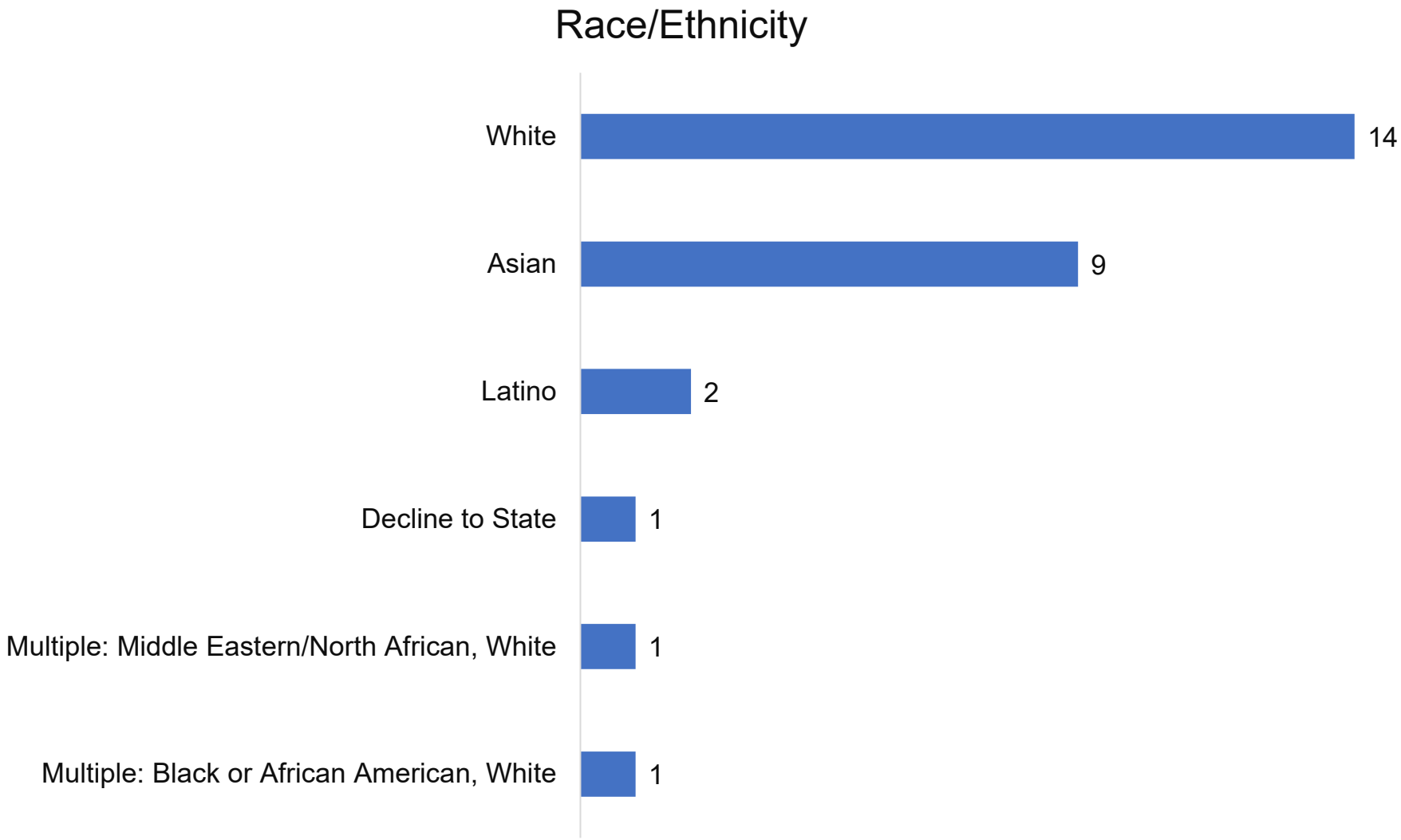


Demographics of Recommended Slate





Demographics of Recommended Slate



Draft Motion from the Subcommittee

- Approve the Recommended Advisory Committee Membership (28 members).
- Appoint the new and reappointed members for a 2-year term.

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Public Comment

HCAI
Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Informational Items

HCAI
Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Timeline of Changes under Federal Budget Reconciliation

Vishaal Pegany, Deputy Director

HCAI

Department of Health Care Access and Information

Key Impacts to California*

Medi-Cal

- Up to 3.4 million of Medi-Cal's around 15 million beneficiaries are at risk of losing health coverage due to HR 1.
  - Approximately 3 million people directly impacted by work requirement and paperwork burdens.
  - Approximately 400,000 by the 6-month eligibility redetermination burden.
- $30+ billion in federal funding is at risk.

Covered California

- Approximately 660,000 Californians will lose access to affordable Marketplace coverage due to the impacts of HR 1, as well the failure to extend enhanced premium subsidies and other changes.
- All of about 2 million consumers will see significantly higher costs in 2026.

Medicare

- Medicare eligibility eliminated for many of California's current and future lawfully present immigrant seniors.

* All numbers are estimates and subject to change.

Key Medicaid Changes

2025

Restricts how states can raise revenue to support their share of the Medicaid program by:

- Revising state-directed payment regulations to cap payment rates at specified levels depending on whether a state expanded Medicaid.
- Prohibiting states from establishing new provider taxes or increasing rates of existing taxes.
- Revising conditions under which states may receive waivers for non-uniform provider taxes used to generate federal matching funds.

2026

- Reduces funding for Emergency Medicaid.
- Eliminates Medicaid/CHIP eligibility for many lawfully present individuals.
- Creates $50 billion Rural Health Transformation program.

2027

- Conditions eligibility for most adults on work with strict verification requirements (Medicaid expansion population).
- Requires redeterminations at least every six months (Medicaid expansion population).
- Limits retroactive coverage to one or two months prior to application.
- Starting date for provider tax structural changes.

2028

- Imposes cost sharing up to $35 for certain services (Medicaid expansion population).
- Starting date for state-directed payment structural changes.

Key ACA Changes

2026

Increases costs for consumers by:

- Not extending enhanced Marketplace subsidies set to expire at the end of 2025.
- Requiring individuals receiving advanced premium tax credits to repay the full amount of any excess, regardless of income.

2027

Eliminates subsidized Marketplace coverage for most lawfully present individuals (e.g., refugees, asylees, and people with Temporary Protected Status) unless a lawful permanent resident (green card holder), Compact of Free Association (COFA) migrant residing in the U.S., or certain immigrants from Cuba and Haiti.

2028

Eliminates automatic renewal of coverage and requires pre-enrollment eligibility verification through new paperwork requirements prior to coverage.

Key Medicare Changes

2026

- Increases the Medicare physician fee schedule by 2.5 percent for one year.
- Decreases the number of orphan drugs eligible for price negotiation under Medicare.

2027

Eliminates Medicare coverage eligibility for most lawfully present individuals (e.g., refugees, asylees, and people with Temporary Protected Status) unless a lawful permanent resident (green card holder), Compact of Free Association (COFA) migrant residing in the U.S., or certain immigrants from Cuba and Haiti.

Considerations for Spending Targets

OHCA will report and enforce targets by market. Reporting by market allows for OHCA to evaluate the impact of the following on spending performance:

- Population characteristics of each market.
- Cost drivers unique to each market.
- Different policy levers and tools in each market for lowering cost growth.
- State and federal policy decisions impacting spending trends.

Considerations for Spending Targets

- The Board may periodically update spending targets so that new information can inform potential changes.
- HR 1 will impact health care entities differently depending on a range of factors including payer mix. Increasing target values across the board could result in higher costs for all commercial market consumers, undermining the goal that health care spending should not grow faster than household income.
- Now and through 2026, OHCA staff will present for discussion proposals on spending target enforcement, including enforcement considerations for exceeding the target. Through this process, OHCA may consider changes in state and federal policy affecting spending.

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Public Comment

HCAI
Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Data Submission Enforcement

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

HCAI
Department of Health Care Access and Information

Statute

Board

Approve:
(b) The board shall approve all of the following:
(2) The scope and range of administrative penalties and the penalty justification factors for assessing penalties.

(c) The director shall present to the board for discussion all of the following:
(5) Review and input on administrative penalties to inform any adjustments to the scope and range of administrative penalties and the penalty justification for assessing penalties.

Office

(h) (1) The director may directly assess administrative penalties when a health care entity has failed to comply with this chapter by doing any of the following:
(A) Willfully failing to report complete and accurate data. …
(E) Knowingly failing to provide information required by this section to the office.
(F) Knowingly falsifying information required by this section.

(2) The director may call a public meeting to notify the public about the health care entity's violation and declare the entity as imperiling the state's ability to monitor and control health care cost growth.

Adopt regulations to implement the statute (HSC 127501 (c)(16), 127501.4 (k), and 127502 (b)(1))

Data Submissions

Data reported in 2024:

- OHCA received all files from the 17 required submitters.
- On average, plans resubmitted each file about 2 times before OHCA accepted all of a plan's files as complete and accurate. OHCA provided technical assistance to all entities.
- 13 plans had submitted all files by October 1, 16 plans by November 1, and all plans by December 18.

Data reported in 2025:

- OHCA requires two new files: Alternative Payment Models (APM) and Primary Care.
- Medi-Cal Managed Care Organizations will submit APM and Primary Care files and OHCA will continue to use total medical expense data from DHCS for MCO reporting.
- Combined with the addition of MCO submissions, plans will submit data by licensed entity, which will expand the number of submitters from 17 to 51. For 2024, submission was at the parent level of the organization.

Data reported in 2026:

- OHCA may add a Behavioral Health file to the data submission.
- Other requirements may be added, or existing requirements may be amended based on lessons learned from 2025 data submission.

Scope and Range of Penalties and Penalty Justification Factors

The Board will approve the Scope and Range of the penalties.

- Penalty amount(s)
- Penalty structure (e.g., per day fee, per member fee, mixed, etc.)

The Board will approve the Penalty Justification Factors.

- These guide OHCA in determining which board-approved penalty amount(s) are assessed.
- The following factors are outlined in statute 127502.5.(d)(6):
  - The nature, number, and gravity of the offenses.
  - The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.
  - The market impact of the entity.
- Other factors can be considered, such as an entity's cooperation and active communication with the Office.

Considerations for Penalty Structure

- The penalty needs to be reasonable, provide an incentive to submit data timely, and deter entities from not submitting or withholding data to evade spending target enforcement.
- OHCA is unable to measure THCE or enforce the target against entities that fail or refuse to submit data.
- If an entity fails to submit data, it may also impact reporting of spending for other health care entities, such as providers organizations that are measured based on attribution of total medical expenses.

In the following illustrative scenarios for discussion today, we focus on a penalty structure for submitters who (1) submit untimely data and (2) fail to submit data. Once data is submitted, submitters have 5 days upon notification to remediate errors with the office (under existing process). This penalty structure would also apply for the submission of inaccurate data.

Potential Penalty Structure Scope and Range

OHCA suggests a two-tiered penalty structure.

A flat penalty for untimely data submission

- The flat penalty encourages timely data submission, while not being overly punitive.
- The penalty would be assessed if the data are submitted after the submission date or prior to the expiration of any approved extension(s).
- A potential flat penalty amount could be $10,000.

A per member penalty for failure to submit data

- The penalty is intended to prevent an entity from evading spending target enforcement by willfully refusing to submit data.
- The per member penalty would be larger than the flat penalty and assessed when an entity fails to submit data.
- OHCA would use progressive enforcement steps and allow multiple opportunities for remediation before assessing this penalty.
- A potential per member penalty could be $5 per member.

Potential Data Submission & Enforcement Process

1. Data due to the office (September 1).
2. Optional extensions per request by the data submitter.
   a. **Extension 1:** A fifteen-day extension requested by the entity by the submission deadline that requires regular check-ins with the office (e.g., email status updates every 3 days details including: the barriers the entity is experiencing; current projected submission date; progress toward completion; any need for technical assistance from the Office).
   b. **Extension 2:** An additional fifteen-day extension can be requested by the entity prior to the first extension ending, contingent upon the entity complying with the requirements of the first extension period. OHCA will require regular check-ins with the office during this period with the same requirements as the first extension.

Potential Data Submission & Enforcement Process

Untimely Data Submission Penalty

3. If data has not been submitted after one or both extension periods or if extension periods are not requested, submitters would be subject to a flat untimely data submission penalty.
4. Submitters would have until November 1 to submit or correct data or be subject to progressive enforcement steps which may result in a Failure to Submit Data Penalty.

Progressive Enforcement Process

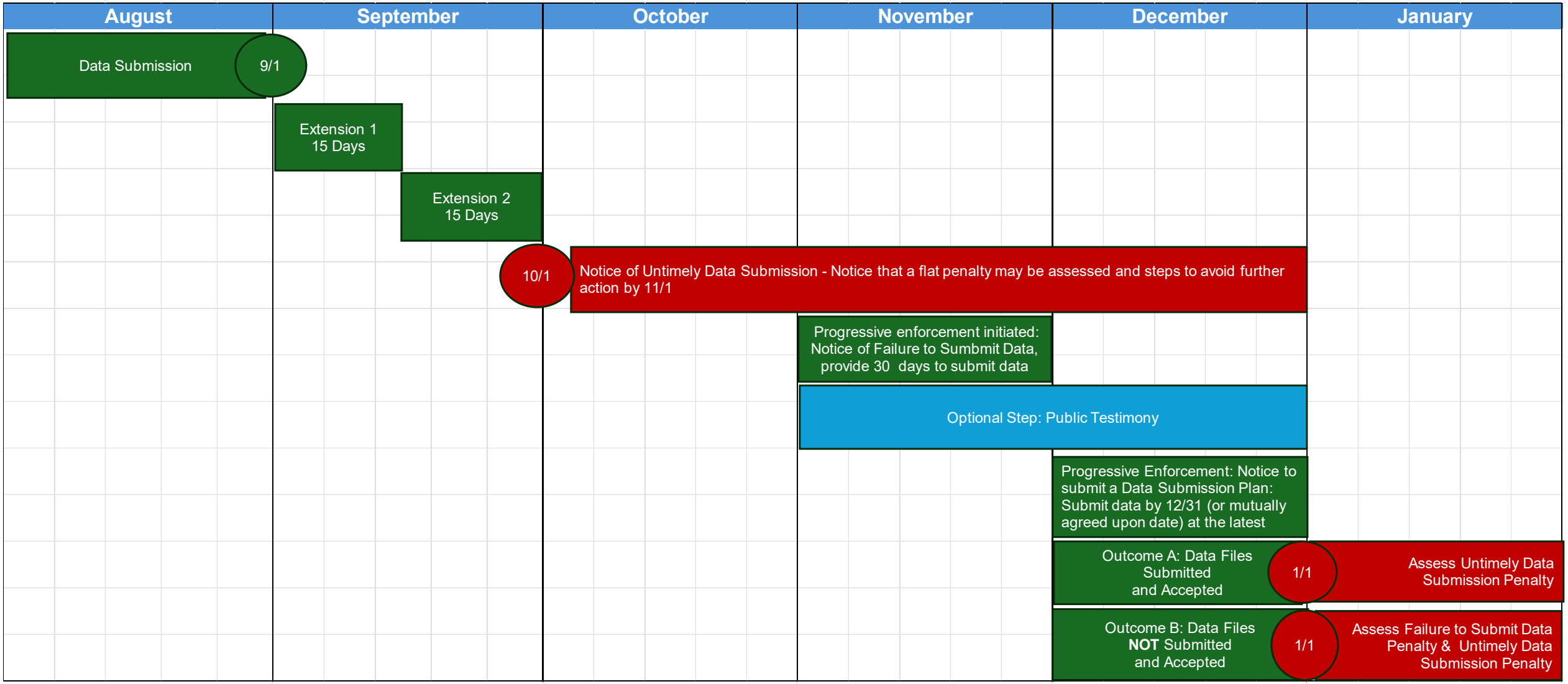
5. If data is not submitted by November 1, progressive enforcement would begin on November 1st with a notice that the submitter has failed to submit data, the Office would provide technical assistance and allow up to 30 days for the submitter to submit data.
6. Optional Step: The Office may compel public testimony.
7. If data is not submitted at the end of the 30 days, the submitter would provide a data submission plan to the Office indicating the actions they will take to submit their data no later than December 31st or by a date agreed upon by the Office.

Potential Data Submission & Enforcement Process

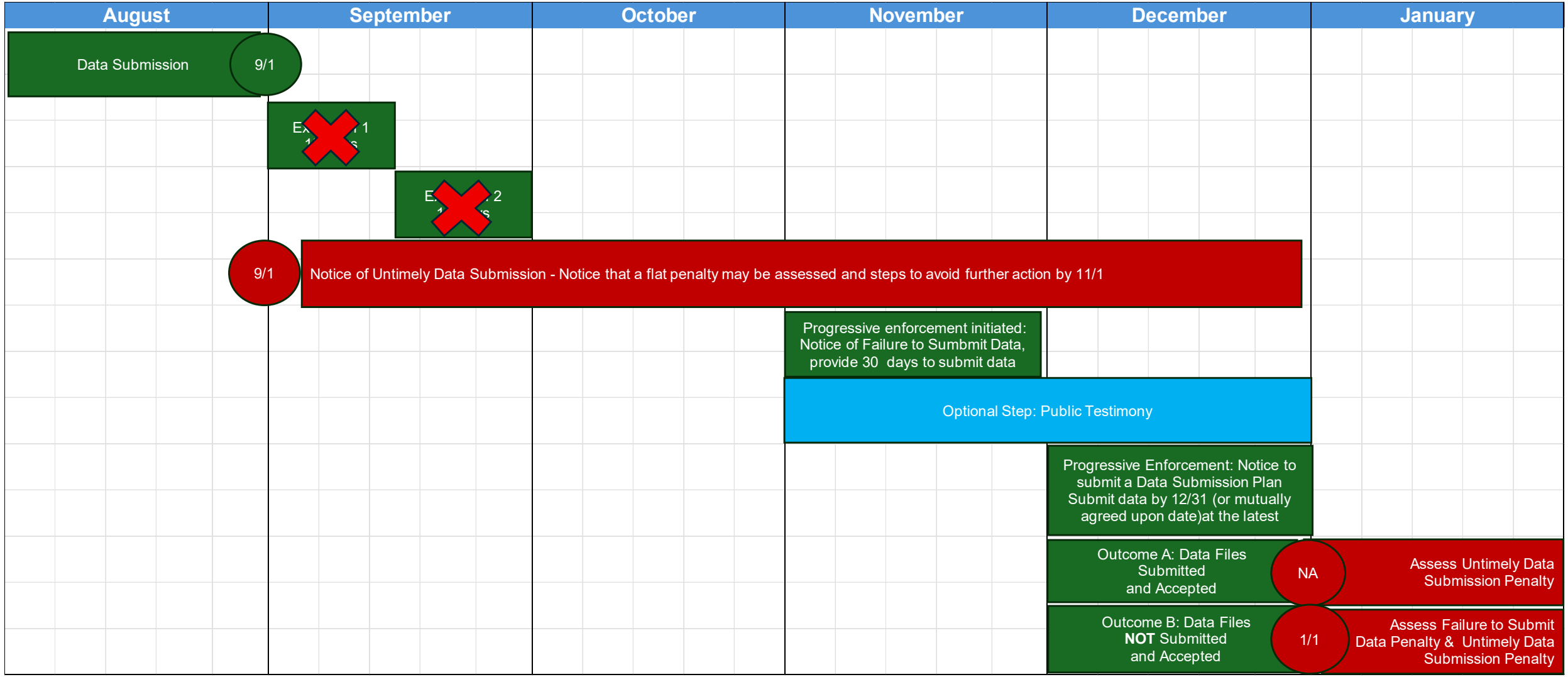
Failure to Submit Data Penalty

8. If data is not submitted by December 31st or the agreed upon date, the entity would be subject to a per member failure to submit data penalty in addition to the untimely data submission penalty.
9. For data submitters that repeatedly fail to submit data, each year the failure to submit data penalty amount would increase.
10. OHCA will make public all penalties once formally assessed.
11. OHCA could pursue other legal remedies in addition to penalties.

Scenario: Both Extensions



Scenario: No Extensions



OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Examples of Penalty Amounts

Plan Info		Outcome A: Untimely Data Submission Penalt	Outcome B: Failure to Submit Data Penalty			
Data Submitter	**Covered Lives (Includes all lines of business)**	**$10,000 (same for all)**	**$0.50/member + $10,000**	**$2/member + $10,000**	**$5/member + $10,000**	**$10/member + $10,000**
Small	80,000	$10,000	$40,000 + $10,000 = **$50,000**	$160,000 + $10,000 = **$170,000**	$410,00 + $10,000 = **$410,000**	$800,000 + $10,000 = **$810,000**
Medium	200,000	$10,000	$100,000 + $10,000 = **$110,000**	$400,000 + $10,000 = **$410,000**	$1,000,000 + $10,000 = **$1,010,000**	$2,000,000 + $10,000 = **$2,010,000**
Large	2,500,000	$10,000	$1,250,000 + $10,000 = **$1,260,000**	$5,000,000 + $10,000 = **$5,010,000**	$12,500,000 + $10,000 = **$12,510,000**	$25,000,000 + $10,000 = **$25,010,000**
Very Large	8,000,000	$10,000	$4,000,000 + $10,000 = **$4,010,000**	$16,000,000 + $10,000 = **$16,010,000**	$40,000,000 + $10,000 = **$40,010,000**	$80,000,000 + $10,000 = **$80,010,000**

Note: This is an illustrative example meant to guide discussion and not a recommendation.

Discussion: Options for Penalty Structure and Amounts

Does the Board have any initial feedback on the penalty structure scope and range? Specifically:

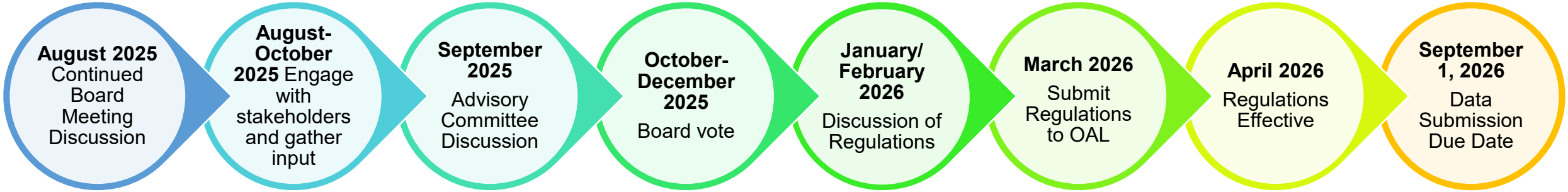
- The two-tiered penalty structure
- The timing of potential penalties
- The untimely data submission penalty amount
- The failure to submit complete and accurate data penalty amount

Discussion: Data Enforcement Steps and Process

Does the Board have any initial feedback on the enforcement process? Specifically:

- The timing and duration of extensions
- The progressive enforcement steps (notice and technical assistance, optional public testimony, data submission plan, penalty)

Next Steps



Note: This timeline aligns with planned regulations for Data Submission Guide updates and other data submission regulations updates.

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Public Comment

HCAI
Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Spending Target Enforcement

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

HCAI
Department of Health Care Access and Information

Timeline for Future Discussion

**Timeline subject to change.*

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Statute - Board Responsibilities

Board

Approve:

(b) The board shall approve all of the following:

(2) The scope and range of administrative penalties and the penalty justification factors for assessing penalties.

Discuss:

(c) The director shall present to the board for discussion all of the following:…

(4) Review and input on performance improvement plans prior to approval, including delivery of periodic updates about compliance with performance improvement plans to inform any adjustment to the standards for imposing those plans.

(5) Review and input on administrative penalties to inform any adjustments to the scope and range of administrative penalties and the penalty justification for assessing penalties.

Statute

Office

Enforcement Considerations and Progressive Enforcement Processes:
(a) The director shall enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, allows each health care entity opportunities for remediation, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability. The director shall consider each entity's contribution to cost growth in excess of the applicable target and any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target. The director shall review information and other relevant data from additional sources, as appropriate, including data from the Health Care Payments Data Program, to determine the appropriate health care entity that may be subject to enforcement actions under this section. Commensurate with the health care entity's offense or violation, the director may take the following progressive enforcement actions:

(1) Provide technical assistance to the entity to assist it to come into compliance.

(2) Require or compel public testimony by the health care entity regarding its failure to comply with the target.

(3) Require submission and implementation of performance improvement plans, including input from the board.

(4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

Statute

Office

Notification and Communication:
(b) Prior to taking any enforcement action, the office shall do all of the following:

(1) Notify the health care entity that it has exceeded the health care cost target.

(2) Give the health care entity not less than 45 days to respond and provide additional data, including information in support of a waiver described in subdivision (i).

(3) If the office determines that the additional data and information meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target, the office may modify its findings, as appropriate.

(4) The director shall consult with the Director of Managed Health Care, the Director of Health Care Services, or the Insurance Commissioner, as applicable, prior to taking any of the enforcement actions specified in this section with respect to a payer regulated by the respective department to ensure any technical assistance, performance improvement plans, or other measures authorized by this section are consistent with laws applicable to regulating health care service plans, health insurers, or a Medi-Cal managed care plan contracted with the State Department of Health Care Services.

Statute

Office

Technical Assistance and Performance Improvement Plans:
(c) (1) If a health care entity exceeds an applicable cost target, the office shall notify the health care entity of their status and provide technical assistance. The office shall make public the extent to which the health care entity exceeded the target. The office may require a health care entity to submit and implement a performance improvement plan that identifies the causes for spending growth and shall include, but not be limited to, specific strategies, adjustments, and action steps the health care entity proposes to implement to improve spending performance during a specified time period. The office shall request further information, as needed, in order to approve a proposed performance improvement plan. The director may approve a performance improvement plan consistent with those areas requiring specific performance or correction for up to three years. The director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability. The standards developed under Article 7 (commencing with Section 127506) may be considered in the approval of a performance improvement plan.

(2) The office shall monitor the health care entity for compliance with the performance improvement plan. The office shall publicly post the identity of a health care entity implementing a performance improvement plan and, at a minimum, a detailed summary of the entity's compliance with the requirements of the performance improvement plan while the plan remains in effect and shall transmit an approved performance improvement plan to appropriate state regulators for the entity.

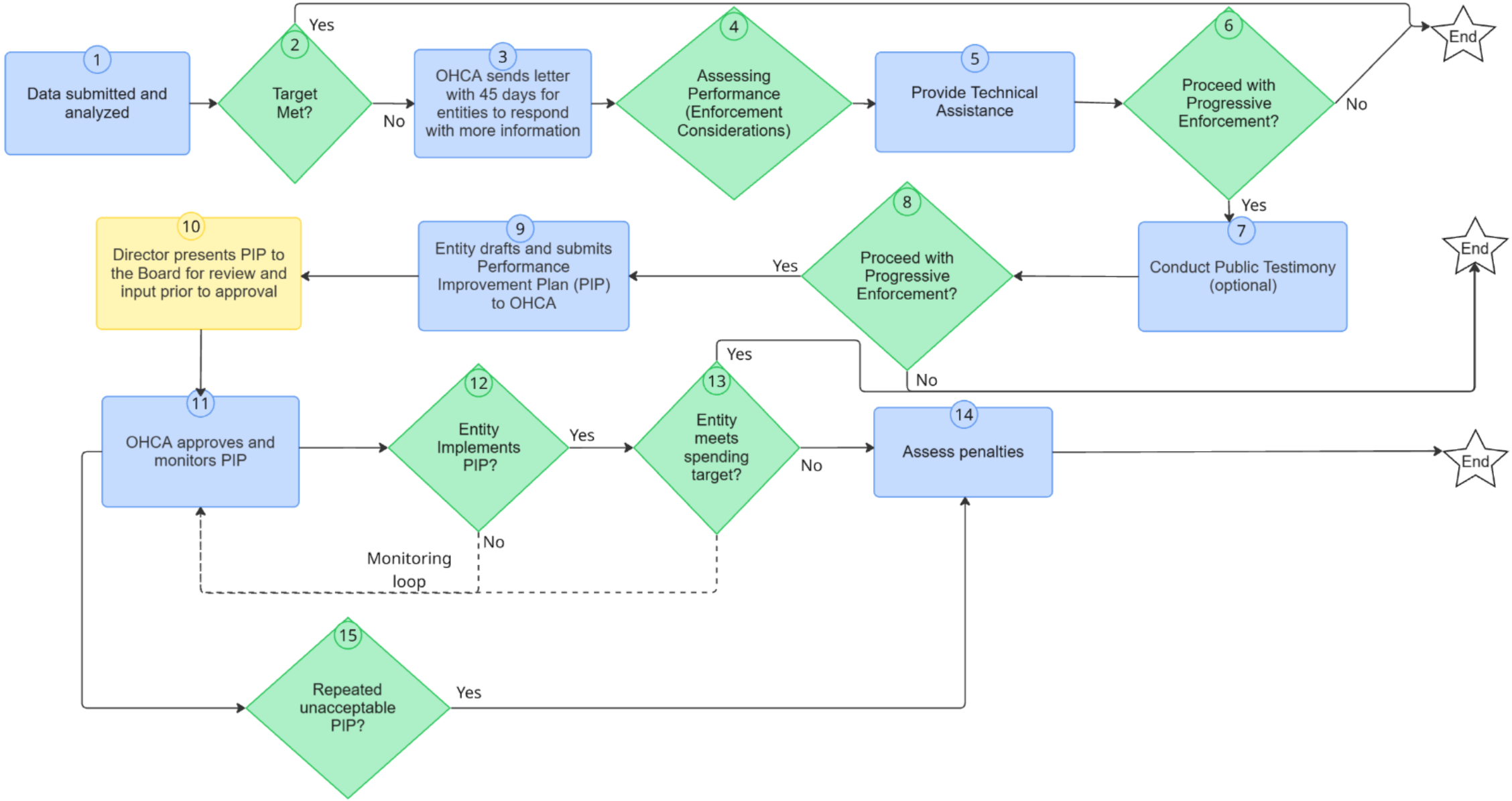
(3) A health care entity shall work to implement the performance improvement plan as submitted to, and approved by, the office. The office shall monitor the health care entity for compliance with the performance improvement plan.

Statute

Office

Optional Waiver of Enforcement:
(i) The office may establish requirements for health care entities to file for a waiver of enforcement actions due to reasonable factors outside the entity's control, such as changes in state or federal law or anticipated costs for investments and initiatives to minimize future costly care, such as increasing access to primary and preventive services, or under extraordinary circumstances, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

Enforcement Process Flow



OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Enforcement Considerations vs. Reasonable Factors

Enforcement Considerations	Reasonable Factors
Factors that OHCA can consider during progressive enforcement Under HSC Section 127502.5(a), the Director shall consider… • each entity's contribution to cost growth in excess of the applicable target and • any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, • factors that contribute to spending in excess of the applicable target, and • the extent to which each entity has control over the applicable components of its cost target.	**Specific to a waiver of enforcement request** Under HSC Section 127501.5(i), the office **may** establish requirements for health care entities to file for a waiver of enforcement actions due to: • *reasonable factors* outside the entity's control, such as changes in state or federal law or • *anticipated costs* for investments and initiatives to minimize future costly care, such as increasing access to primary and preventive services or • under *extraordinary circumstances*, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

Enforcement Considerations in Other States

Massachusetts (Regulatory Factors)	Oregon (Reasonableness Factors)
• Baseline spending and spending trends over time, including by service category • Pricing patterns and trends over time • Utilization patterns and trends over time • Population(s) served, payer mix, product lines, and services provided • Size and market share • Financial condition, including administrative spending and cost structure • Ongoing strategies or investments to improve efficiency or reduce spending growth over time • Factors leading to increased costs that are outside the CHIA-identified Entity's control • Any other factors the Commission considers relevant.	• Changes in federal or state law • Changes in mandated benefits • New pharmaceuticals or treatments • Changes in taxes (or other admin) • "Acts of God" • Investments to improve health/ health equity • High-cost outliers • Increased behavioral health spending after state raised Medicaid rates • Longer inpatient stays because hospitals were unable to discharge patients to other facilities • Patients with more than $1 million in annual costs, especially for pediatric practices • Increased Medicaid non-claims spending, likely quality payments and COVID-related payments • Increased frontline workforce costs • Service expansions to meet community needs

Enforcement Considerations

Potential enforcement considerations that may contribute to spending in excess of the applicable target include:

- Changes in state or federal law (e.g., Medicare or Medi-Cal reimbursement, new coverage mandates)
- Investments in primary and/or preventive care
- Acts of God or catastrophic events
- High-cost drugs
- Others?

How should OHCA distinguish between controllable overspending and external cost pressures?

Summary of OHCA Engagement on High-Cost Drugs

OHCA Engagement on High-Cost Drugs

- OHCA met with 8 stakeholders (health plans, physician organizations, hospitals, consumer advocates) between May and July; one meeting remains in late-July.
- Discussions focused on high-cost drugs as a mitigating factor for exceeding the spending target. OHCA is trying to understand:
  - the extent of control over drug costs.
  - trends in high-cost drugs.
  - relationships between various entities in the workflow of purchasing and administering drugs.
  - feedback from entities on how to operationalize a mitigating factor for high-cost drugs.
- Focused primarily on physician-administered drugs (vs. retail pharmacy).

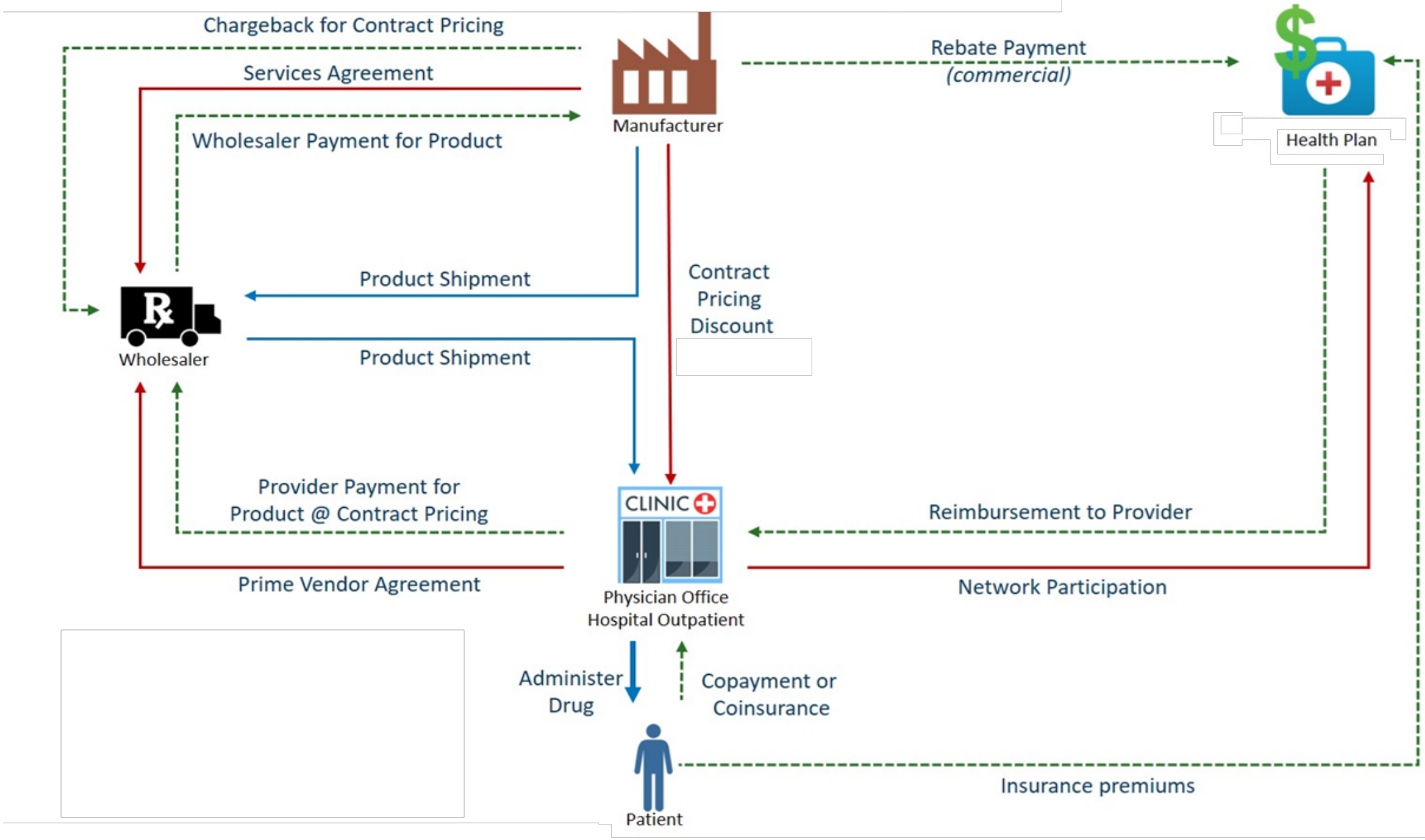
Retail vs Physician-Administered Drugs

There are significant price differences for the same drug depending on whether it is administered in a hospital outpatient department, inpatient department, physician's office, or purchased at a retail pharmacy.

Retail Drugs	Physician-Administered Drugs
• Purchased by patient at retail pharmacy. • Covered under pharmacy benefit of a health plan. • Includes oral medications, some injectables (like insulin), and other medications that can be self-administered.	• Usually purchased by physician's office or hospital and administered to patient. • Covered by the medical benefit of a health plan. • Includes infusions, injections, and medications administered in a clinical or hospital setting.

Stakeholder Roles

Health Plans	• Contract with Pharmacy Benefit Managers (PBMs) to manage drug benefits, including by categorizing drugs into tiers • Sometimes have choice in formulary design • Pay for drug costs and administration fees
Physician Organizations	• Prescribe medications and stay informed about new therapies • Administer physician-administered drugs • Monitor patient responses and manage potential drug interactions
Hospitals	• Obtain medications from licensed pharmaceutical wholesalers or group purchasing organizations • Manage inpatient and outpatient drug administration
Consumer Advocates	• Educate the public • Advocate for policy changes that make drugs more affordable and accessible • Support accountability for drug companies and health care entities



Fein, Adam J. (2021, October 26). Follow the Vial: The Buy-and-Bill System for Distributing and Reimbursing Provider-Administered Outpatient Drugs. https://www.drugchannels.net/2021/10/follow-vial-buy-and-bill-system-for.html

PBMs vs GPOs

Pharmacy Benefit Managers (PBMs)

- Emerged in the 1960s to manage prescription drug benefits for insurance companies, handling claims processing and reimbursement.

- **Current Trends**
  - **Formulary Management -** PBMs determine which drugs are covered by insurance plans and at what cost to the patient.
  - **Rebates and Pricing -** PBMs negotiate rebates with pharmaceutical companies, but the impact of these rebates on drug prices and patient costs is a subject of ongoing debate.
  - **Pharmacy Networks -** PBMs establish and manage networks of pharmacies that are covered under insurance plans, influencing patient access to medications.
  - **Vertical Integration -** Some PBMs have merged with or been acquired by insurance companies, pharmacies, or pharmaceutical companies, raising concerns about potential conflicts of interest and anticompetitive practices.
  - **Mail Order Drugs -** PBMs are increasingly involved in mail-order pharmacy operations, sometimes owning or partnering with mail-order pharmacies.

Group Purchasing Organizations (GPOs)

- Emerged in the early 20th century as a way for hospitals and other healthcare providers to pool their purchasing power to negotiate lower prices from suppliers.
- Leveraged buying power allows smaller entities to access the same discounts as larger organizations.

- **Current Trends**
  - GPOs have expanded their roles beyond just procurement, incorporating data analytics, logistics, and digital transformation strategies to improve supply chain efficiency.
  - GPOs have faced criticism for potentially limiting competition and choice, and for the complexity of their operations and financial structures.

Key Observations

- Health care entities all note limited ability to control drug costs.
- Anti-inflammatory, oncology, ophthalmic, diabetes and obesity drugs were identified as high-cost drugs driving spending.
- New therapies and new uses of existing high-cost drugs were also identified as key drivers of drug costs; however, the regular introduction of biosimilars and generics helps reduce cost growth.
- Changes in pharmacy benefit managers (PBM) and contracts are common and can result in changes to prices and formularies.
- The lack of transparency in pharmaceutical pricing means entities along the supply chain can increase costs and mark-ups.

Key Observations

- Suggestions to OHCA include:
  - Reference Oregon's model when developing OHCA's mitigating factor for high-cost drugs.
  - Reference data from the NASHP Hospital Cost Tool, like the cost-to-charge ratio
  - Use charge masters, encounter data, hospital pharmacy reports, high-cost drug carve outs from contracts, and 340B discount information to verify drug costs and trends.
  - Collect data on which drugs are highest cost and determine their impact on an entity's cost growth.
  - Evaluate the division of financial responsibility between a provider and a payer.
  - Examine any cost savings from PBMs.

Health Plans

Plans report that their influence over drug costs is limited and dependent upon contracts with pharmacy benefit managers (PBMs) and group purchasing organizations (GPOs).

Drug Cost Drivers	Cost Mitigation
• High-cost drugs like autoimmune, anti-inflammatory, rheumatoid arthritis, oncology, diabetes, and skin condition treatments • Increased utilization • New therapies	• Contracting with multiple PBMs • Developing creative group purchasing arrangements • Managing utilization via prior authorizations • Presenting cost information to prescriber and patient before prescription

Health Plans

- Plans noted they often carry financial risk for many injectable drugs due to requirements under Section 1375.8 of the Health and Safety Code (commonly referred to as Richman Bill). Under the Richman Bill, health plans cannot delegate risk for the following injectables unless there is negotiation with the capitated provider to assume that risk:
  - Injectable chemotherapeutic medications and injectable adjunct pharmaceutical therapies for side effects
  - Injectable medications or blood products used for hemophilia
  - Injectable medications related to transplant services
  - Adult vaccines
  - Self-injectable medications
  - Other injectable medication or medication in an implantable dosage form costing more than two hundred and fifty dollars ($250) per dose
- These negotiation results in varying configurations for financial risk between plans and providers, such as Full Richman carve out, chemotherapy risk only, or high-cost risk.

Health Plans

- Plans noted the following barriers to managing costs:
  - Changing PBMs for a better price can also lead to changes in formularies
  - Specialty drugs may have limited distribution channels through high-cost facilities
  - Manufacturer co-pay cards encourage patients to choose branded drugs
  - Allowing patient choice for drugs may lead to selection of high-cost brands
  - Hospital markups on drugs beyond the wholesale price
- Plans noted that Oregon's broad approach to high-cost drugs as a reasonable factor is a good model and suggested addition consideration of:
  - entry of new high-cost drugs
  - new uses or updated guidance about length of course or where they should be administered
  - increases in demand, cost, or availability

Physician Organizations

Physician organizations report that their influence over drug costs is limited and depends on negotiations with health plans for higher reimbursement payments.

Drug Cost Drivers	Cost Mitigation
• Oncology agents • Ophthalmic injections • New high-cost drugs • New uses of high-cost drugs • Tariffs on supplies and medications • Increased demand (new vaccines, aging baby boomers) • Lack of savings passed on to physicians from rebates • Inflation	• Negotiating with health plans to remove high-cost drugs from their division of financial responsibility • Utilizing health plans' drug protection plans • Internal cost-savings programs like encouraging the use of biosimilars, site-of-service redirection (from higher cost facilities to preferred sites) • Reference pricing (setting a maximum price for a group of similar drugs)

Physician Organizations

- **Retail benefit drugs:** Generally, physician organizations do not bear financial risk for retail drugs unless they are a part of a health system that has risk for some or all retail drugs.
- **Medical benefit drugs:** Financial risk for physician organizations can vary in their financial responsibility for office-based medications, vaccines, and outpatient medications delivered in outpatient facilities. Some have full risk for home infusion medications and inpatient medications.
- Many high-cost drugs are rolled into hospital claims that are billed under the medical benefit; these are not as easy to identify compared to retail pharmacy claims.
- A physician organization reported that when there is a material change in their drug costs (new market entrant, increase in utilization, other supply chain issues) that would result in a significant financial impact, they try to renegotiate their capitation rate to account for the change. An example is new vaccines. Others try to negotiate financial risk back to the health plan but may not be successful because of how plans treat/classify drugs.

Physician Organizations

- Physician organizations reported that a small number of high-cost drugs are responsible for outsized amounts of their cost growth and drug costs, matching trends seen elsewhere in the market.
    - For example, Keytruda has a cost of ~$200K per patient per year and has experienced a significant increase in usage as it had one second-line indication in 2024 and increased to 49 indications with multiple first-line indications and used in combo therapy with other high-cost medications. Usage is a among a small portion of members, but it represents an outsized share of total medical drug spend.
- Physician organizations suggested that OHCA exclude drugs from the cost target with new codes or a new first line treatment indication on claims, exclude a limited number of high-cost drugs with no cost-effective alternative, and potentially drill down to a subset of drug codes that could be compared year-over-year.

Hospitals

Hospitals report that their control over the cost of drugs is limited to what their GPO or PBM is able to negotiate for them, what they are reimbursed for by Medi-Cal and Medicare, and health plan formulary decisions.

Drug Cost Drivers	Cost Mitigation
• Oncology agents, specialty biologics (auto-immune, anti-inflammatory), cell and gene therapies (including CAR-T), as well as ophthalmic injections; expanded utilization (such as GLP1s being used for cardiovascular treatment)	• Switching GPOs to get better pricing but some noting that it is not easy • Negotiating to exclude high-cost drugs in contracts • Hospitals noted that some high-cost drugs mitigate overall spending -- curative medications like high-cost sickle cell disease drugs are one example.

Hospitals

- For critical access hospitals that bill by charges, they have to charge over 2x the average wholesale price of the drug to cover the cost of labor and supplies.
- One hospital noted that because they are paid per diem or capitation on the inpatient side, they don't get paid more for providing more services and/or drugs.
- A hospital noted that as an employer they looked at drug costs for their self-insured plan and noted savings opportunities, such as a dozen patients alone switching from Humira to biosimilars would save millions. To achieve broader savings, it would require prescriber and patient education and being able to obtain this data from their PBM.
- Some hospitals discourage/disallow white- or brown- bagging because they can provide all drug needs through their own pharmacies. This approach enables them to reduce delays for patients and minimize waste.

White-bagging: Drugs are shipped directly from specialty pharmacy to medical providers for administration.
Brown-bagging: Drugs are dispensed to patients, who then bring the drug to their medical provider for administration.

Hospitals

- One hospital noted that they are able to renegotiate their contracts with GPOs when there's been a material change – like new vaccines, new high-cost medications, etc.
- One hospital noted that treatments for some indications like cancer can change from year-to-year, impacting costs and potentially impacting performance against the targets.
- Hospitals suggested OHCA make cost adjustments for inflation, expensive and rare therapies, and whether hospitals opened any new services that are impacting drug spending. One hospital suggested that OHCA focus on the misuse of high-cost drugs rather than volume when considering high-cost drugs as a spending factor.
- Hospitals suggested the impact of high-cost drugs could be measured by: using drug revenue codes from claims to compare high-cost drugs year-over-year; evaluating evidence of changes in costs like a charge master or hospital pharmacy reports; and using encounter data submitted to health plans to tease out medical benefit pharmacy costs bundled in capitation payments.

Consumer Advocates

- Consumer advocates suggested that OHCA should look to the NASHP Hospital Cost Tool to reference what Medicare FFS reimburses for drugs and comparing how many times a hospital is charging over Medicare.
- Advocates noted that markups of drug costs are driving high spending. While some markup is understandable, they stated that markups 4-5 times of Medicare is unjustified. Markup behavior may be associated with the market power of the entity.
- Lastly, advocates said that health plans, especially those with a large national footprint, should have purchasing power to drive down drug costs.

Board Discussion

Does the Board have any initial feedback on inclusion of high-cost drugs as an enforcement consideration? Specifically:

- The size and impact of drugs on an entity exceeding the target. For example, some costly drugs are highly utilized (e.g., GLP-1s) while other drugs have relatively low utilization but have extraordinarily high launch prices (e.g., cell and gene therapies).
- Significant market changes: some changes increase costs such as new therapies while other changes lower costs, such as expiration of patents.
- Determining who to hold accountable in varying configurations of financial risk in HMO-based capitated, delegated arrangements.
- Excessive markup behavior by providers and purchasing power of payers.
- Data and information health care entities should submit to distinguish between controllable overspending and external cost pressures.

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAI

Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

General Public Comment

Written public comment can be emailed to:
ohca@hcai.ca.gov
To ensure that written public comment is included in the posted board materials, e-mail your comments at least 3 business days prior to the meeting.

HCAI
Department of Health Care Access and Information

Next Board Meeting:
August 26, 2025
10 am

Location:
2020 West El Camino Ave, Conference Room 900, Sacramento, CA 95833

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Adjournment

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Appendix

HCAI

Department of Health Care Access and Information

Additional Spending Target Enforcement Statutory Provisions

Statute

Office

Confidential Information:

(c)(4) The board, the members of the board, the office, the department, and employees, contractors, and advisors of the office and the department shall keep confidential all nonpublic information and documents obtained under this subdivision, and shall not disclose the confidential information or documents to any person, other than the Attorney General, without the consent of the source of the information or documents, except in an administrative penalty action, or a public meeting under this section if the office believes that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations. Prior to disclosure in a public meeting, the office shall notify the relevant party and provide the source of nonpublic information an opportunity to specify facts documenting why release of the information is damaging or prejudicial to the source of the information and why the public interest is served in withholding the information. Information that is otherwise publicly available, or that has not been confidentially maintained by the source, shall not be considered nonpublic information. This paragraph does not limit the board's discussion of nonpublic information during closed sessions of board meetings.

(5) Notwithstanding any other law, all nonpublic information and documents obtained under this subdivision shall not be required to be disclosed pursuant to the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records.

Statute

Office

Administrative Penalties:
(d) (1) If the director determines that a health care entity is not compliant with an approved performance improvement plan and does not meet the cost target, the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target. An entity that has fully complied with an approved performance improvement plan by the deadline established by the office shall not be assessed administrative penalties. However, the director may require a modification to the performance improvement plan until the cost target is met.

(2) The administrative penalty shall be deposited into the Health Care Affordability Fund.

(3) Prior to assessing an administrative penalty against a health care entity, the director may consider related provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, associated with Medi-Cal payments, such as expenditures by providers or provider-affiliated entities that serve as the nonfederal share associated with Medi-Cal reimbursement.

(4) To the extent that an administrative penalty is related to a Medi-Cal expenditure, including federal financial participation, the office shall coordinate with the State Department of Health Care Services to ensure appropriate treatment and return of any federal funds pursuant to Subpart F commencing with Section 433.300 of Part 433 of Title 42 of the Code of Federal Regulations.

(5) If, after the implementation of one or more performance improvement plans, the health care entity is repeatedly noncompliant with the performance improvement plan, the director may assess escalating administrative penalties that exceed the penalties imposed under paragraphs (1) and (2) of this subdivision and paragraph (4) of subdivision (a).

Statute

Office

Administrative Penalies:
(d)(6) The director shall consider all of the following to determine the penalty:

(A) The nature, number, and gravity of the offenses.

(B) The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.

(C) The market impact of the entity.

(e) Administrative penalties shall not constitute expenditures for the purpose of meeting cost targets. The imposition of administrative penalties shall not alter or otherwise relieve the health care entity of the obligation to meet a previously established cost target or a cost target for subsequent years.

Statute

Office

Payers, Fully Integrated Delivery Systems, and Adverse Impacts:
(f) (1) For payers and fully integrated delivery systems, the director also shall enforce cost targets established by Section 127502 against the cost growth for administrative costs and profits.

(2) If a payer exceeds the target for per capita growth in total health care expenditures, but has met its target for administrative costs and profits, the payer shall submit relevant documentation or supporting evidence for the drivers of excess cost growth.

(3) This subdivision does not relieve a payer of its obligation to meet targets for per capita growth in total health care expenditures established by Section 127502, and does not limit enforcement actions for payers under this section.

(g) If data indicate adverse impacts on cost, access, quality, equity, or workforce stability from consolidation, market power, or other market failures, the director may, at any point, require that a cost and market impact review be performed on a health care entity, consistent with Section 127507.2.

Statute

Office

Directly Assessing Administrative Penalties:
(h) (1) The director may directly assess administrative penalties when a health care entity has failed to comply with this chapter by doing any of the following:

(A) Willfully failing to report complete and accurate data.

(B) Repeatedly neglecting to file a performance improvement plan with the office.

(C) Repeatedly failing to file an acceptable performance improvement plan with the office.

(D) Repeatedly failing to implement the performance improvement plan.

(E) Knowingly failing to provide information required by this section to the office.

(F) Knowingly falsifying information required by this section.

(2) The director may call a public meeting to notify the public about the health care entity's violation and declare the entity as imperiling the state's ability to monitor and control health care cost growth.

Statute

Office

Remedies and Rights:
(j) As applied to the administrative penalties for acts in violation of this chapter, the remedies provided by this section and by any other law are not exclusive and may be sought and employed in any combination to enforce this chapter.

(k) Following an administrative hearing, a health care entity adversely affected by a final order imposing an administrative penalty authorized by this chapter may seek independent judicial review by filing a petition for a writ of mandate in accordance with Section 1094.5 of the Code of Civil Procedure.

(l) After an order imposing an administrative penalty becomes final, and if a petition for a writ of mandate has not been filed within the time limits prescribed in Section 11523 of the Government Code, the office may apply to the clerk of the appropriate court for a judgment in the amount of the administrative penalty. The application, which shall include a certified copy of the final order of the administrative hearing officer, shall constitute a sufficient showing to warrant the issuance of the judgment. The court clerk shall enter the judgment immediately in conformity with the application. The judgment so entered has the same force and effect as, and is subject to all the provisions of law relating to, a judgment in a civil action, and may be enforced in the same manner as any other judgment of the court in which it is entered.

Statute- Health Care Affordability Fund

127501.8. (a) There is hereby established in the State Treasury the Health Care Affordability Fund for the purpose of receiving and expending revenues collected pursuant to this chapter. This fund is subject to appropriation by the Legislature.

(b) All moneys in the fund shall be expended in a manner that prioritizes the return of the moneys to consumers and purchasers.

(c) The office may identify any opportunities to leverage existing public and private financial resources to provide technical assistance to health care entities and support to the office. Any private or public moneys obtained may be placed in the Health Care Affordability Fund, for use by the office upon appropriation by the Legislature.

Statute

127502.5. (k) Following an administrative hearing, a health care entity adversely affected by a final order imposing an administrative penalty authorized by this chapter may seek independent judicial review by filing a petition for a writ of mandate in accordance with Section 1094.5 of the Code of Civil Procedure.

(l) After an order imposing an administrative penalty becomes final, and if a petition for a writ of mandate has not been filed within the time limits prescribed in Section 11523 of the Government Code, the office may apply to the clerk of the appropriate court for a judgment in the amount of the administrative penalty. The application, which shall include a certified copy of the final order of the administrative hearing officer, shall constitute a sufficient showing to warrant the issuance of the judgment. The court clerk shall enter the judgment immediately in conformity with the application. The judgment so entered has the same force and effect as, and is subject to all the provisions of law relating to, a judgment in a civil action, and may be enforced in the same manner as any other judgment of the court in which it is entered.